Washington Dental Service

Benefits Booklet

City of Seattle

Seattle Police Officers' Guild

Effective January 1, 2010
and 2011 Updates

Delta Dental Premier®

City of Seattle Policy #3
Seattle Police Officer's Guild

Washington Dental Service
Plan **#00160**

Effective **January 1, 2010**

City of Seattle

Dental Program
#00160 – Policy 3

Inside ...

What If My Dentist Is A Nonparticipating Dentist?

If you select a dentist who is not a Delta Dental Participating Dentist of Washington Dental Service, you are responsible for having your dentist complete and sign a claim form. We accept any American Dental Association-approved claim form that your dentist may provide. It is up to you to ensure that the claim is sent to Washington Dental Service. Since Washington Dental Service does not have fees on file for Nonparticipating Dentists, the payment for services performed by a nonparticipating dentist is based upon actual charges or Washington Dental Service's allowable fees for Nonparticipating Dentists, whichever is less. The payment will be issued in both your name and that of your dentist unless you specifically authorize that payment be made directly to your dentist.

Can I Receive Dental Care Outside The State of Washington?

If you receive treatment from a dentist outside Washington State, you are responsible for having the dentist complete and sign a claim form. It is up to you to pay the dentist's bill and submit the claim to Washington Dental Service. Payment will be based upon actual charges or Washington Dental Service's maximum allowable fees for out of state dentists, whichever is less.

Where May I Obtain Claim Forms?

You may obtain claim forms from your Department Human Resources or Payroll Representative or WDS. WDS will not be obligated to pay for treatment performed in the event claim forms are submitted for payment more than 12 months after the date of completion of treatment. Orthodontic claims must be submitted within 12 months of the initial banding date.

Is There A Program Maximum?

Yes. The maximum amount payable by WDS for Class I, II & III Covered Dental Benefits for each eligible person is $1,500 per calendar year (January 1 through December 31). Charges for dental procedures requiring multiple treatment dates shall be considered incurred on the date the service is completed. Amounts paid for such procedures will be applied to the program maximum based on such incurred date.

Orthodontic benefits for an eligible child are limited to a $2,000 lifetime maximum and such benefits are in addition to the $1,500 calendar year maximum.

Is There A Program Deductible?

No.

Is A Predetermination of Benefits Required?

A predetermination of benefits is a service that is offered and is very beneficial; however, it is not mandatory. It is strongly suggested that an orthodontic treatment plan be submitted to, and a predetermination be made by, WDS prior to commencement of treatment. A predetermination is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the secondary payment of benefits, the secondary payment is not covered.

g. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan.

h. If the above order does not establish the primary plan, then the plan that has covered that person for the longest period of time is the primary plan.

If you are covered by more than one health plan, you or your provider should file all your claims with each plan at the same time. If Medicare is your primary plan, Medicare may submit your claims to your secondary carrier for you.

If you are covered by more than one health benefit plan, and you do not know which your primary plan is, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

Note: All health plans have timely claim filing requirements. If you or your provider fails to submit your claim to a secondary health plan within the plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

If payments that should have been made under this plan are made by another plan, WDS has the right, at its discretion, to remit to the other plan the amount it determines appropriate. To the extent of such payments, WDS is fully discharged from liability under this plan.

In the event WDS makes payments in excess of the maximum amount, WDS shall have the right to recover the excess payments from the patient, the subscriber, the provider or the other plan.

MySmile® Personal Benefits Center

The MySmile® personal benefits center, available on Washington Dental Service's Web site at www.DeltaDentalWA.com, is customized to your individual needs and provides you with the answers to your most pressing questions about your dental coverage. A simple, task-oriented, self-service interface, MySmile lets you search for a dentist in your plan network, review your recent dental activity, check details of your plan coverage, view and print your ID card, check the status of current claims, and more.

Health Insurance Portability and Accountability Act (HIPAA)

Washington Dental Service is committed to protecting the privacy of your dental health information.

The Health Insurance Portability and Accountability Act (HIPAA) requires WDS to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting www.deltadentalwa.com. You may also request a printed copy by calling the WDS privacy hotline at (206) 985-5963.

If Both Husband and Wife are Covered by WDS, either as City Employees or by Different Employers, What is the Calendar Year Maximum?

In such instances the calendar year maximum for each of the employees and for an eligible dependent of both employees will equal the total of the maximum(s) specified in each of the two plans.

In either of the situations above, the amount paid by WDS, together with amounts from other group programs, will not exceed 100 percent of dental expenses incurred; and the total amount payable by WDS will not exceed the amount which would have been paid for covered benefits if there were not other programs involved.

Employee Eligibility

You are in an Eligible Class if you: (a) work at least 80 hours per month and are an active, regular full-time employee or a temporary employee in a benefits-eligible assignment and work at least 80 hours per month, or (b) are a temporary employee who is not in a benefits-eligible assignment, but have worked at least 1,040 cumulative non-overtime hours and at least 800 non-overtime hours in the previous 12 month period. You must not be represented by a bargaining group for which a separate Summary of Coverage is available. Your Employer will provide you with this information.

Your Eligibility Date is the effective date of this Plan if you were a regular employee in an Eligible Class on the date the Plan became effective. Otherwise, coverage begins for you and your dependents on your first day of employment if that date is: (a) the first calendar day of the month designated as a City business day, or (b) the first calendar day of the month designated/recognized as the first working day for the shift to which you are assigned, whichever is later. If your employment begins after said date, your coverage will begin the following month.

Your Eligibility Date if you are a temporary employee in an Eligible Class but not in a benefits-eligible assignment, is the first day of the calendar month following the date application is made and the rate is paid, or the date designated by your Employer if application is made during an open enrollment period. If you are a temporary employee in a benefits-eligible assignment, your coverage begins the first calendar day of the month designated as a City business day. If your employment begins after said date, your coverage will begin the following month.

An employee for whom coverage already became effective, but who is absent without pay on the first day of the calendar month and returns by the 15th of the month will not have a lapse in coverage. Coverage for an employee who returns after the 15th of the month will begin the first day of the following calendar month. However, an employee who is absent without pay for 15 consecutive calendar days or less will not have a lapse in coverage.

Continuation of Coverage

Employees on paid sick leave or vacation or on an approved leave of absence of 15 days or less shall be eligible for City-paid contributions for coverage for themselves and eligible dependents for the period away from work.

Dependent Eligibility

Eligible Dependents include:

- The employee's legal spouse or domestic partner named on the Affidavit of Marriage/Domestic Partnership on file with the City.
- Unmarried natural, adopted, legally placed ward or stepchild from birth through 24.
- In the case of divorced parents, unmarried children are eligible and may be enrolled by the parent (an eligible employee) who is legally responsible for health care benefits, regardless of whether or not the child is primarily dependent upon the employee for support. The child shall be eligible from birth through 24.

A child will be considered an eligible dependent as an adopted child if the following conditions are met: 1) the child has been placed with the eligible employee for the purpose of adoption under the laws of the state in which the employee resides; and 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing (see "Special Enrollment").

Coverage for an unmarried dependent child over the limiting age will not be terminated if the child is and continues to be both 1) incapable of self sustaining employment by reasons of developmental disability (including mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals) or physical handicap and 2) chiefly dependent upon the eligible employee for support and maintenance, provided proof of incapacity and dependency is furnished to WDS within 31 days of the child's attainment of the limiting age and the child was an eligible dependent upon attainment of the limiting age. WDS reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

Pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), the plan also provides coverage for a child, even if the parent does not have legal custody of the child or the child is not dependent on the parent for support. This applies regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. If parent is not enrolled in dental benefits, he/she must enroll for coverage for himself/herself and the child. If the plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. A custodial parent, a state agency or an alternate recipient may enroll a dependent child under the terms of a valid QMCSO. A child who is eligible for coverage through a QMCSO may not enroll dependents for coverage under the plan.

Dependent coverage terminates at the end of the month in which the parent's coverage terminates, or when the dependent ceases to be eligible, whichever occurs first.

You may terminate coverage of an eligible dependent only coincident with a subsequent renewal or extension of the dental plan. Once an eligible employee terminates such eligible dependents coverage, the coverage cannot be reinstated, unless there is a change in family status.

2. **Marriage, Birth or Adoption**

If you declined enrollment in this Plan, you may apply for coverage for yourself and your eligible dependents in the event of marriage, birth of a child(ren), or when you or your spouse assume legal obligation for total or partial support of a child(ren) in anticipation of adoption.

- Marriage — WDS requests the application for coverage be made within 31 days of the date of marriage. If an additional Premium for coverage is required and enrollment and payment is not completed within the 31 days, the eligible dependent may be enrolled during the next open enrollment.
- Birth — A newborn shall be covered from and after the moment of birth. WDS requests the application for coverage be made within: 60 days of the date of birth. If an additional premium for coverage is required and enrollment and payment is not completed within the 60 days, the eligible dependent may be enrolled during the next open enrollment, but coverage will be provided in any event.
- Adoption — WDS requests the application for coverage be made within 60 days of the date of assumption of a legal obligation for total or partial support of the child in anticipation of adoption. If an additional premium for coverage is required and enrollment and payment is not completed within the 60 days, the eligible dependent may be enrolled during the next open enrollment.

Extension of Benefits

In the event a person ceases to be eligible, or in the event of termination of this Plan, WDS shall not be required to pay for services beyond the termination date. The exception will be for the completion (within three weeks) of procedures requiring multiple visits to complete the work started while coverage was in effect and that are otherwise benefits under the terms of this plan.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer or individual may be committing insurance fraud, please contact the WDS hotline for Fraud & Abuse at (800) 211-0359 or (206) 985-5927. You may also want to alert any of the appropriate law enforcement authorities listed:

- The National Insurance Crime Bureau (NICB). You can reach the NICB at 1 (800) 835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- The Office of the Insurance Commissioner (OIC) at (360) 725-7263 or go to www.insurance.wa.gov for more information.

Extension of Coverage

The "Continuation of Coverage" (COBRA) legislation passed into federal law (PL99-272 and as amended by PL104-191) allows employees and their dependents to continue dental coverage, on a self-pay basis, in certain circumstances where coverage would otherwise cease.

You and/or your covered dependents may continue coverage for up to 18 consecutive months if you lose coverage due to:

- The first day after the date of the election that the individual continuing coverage is covered under another group health plan. However, if the new coverage does not cover a specific pre-existing condition of the individual, the affected individual may continue COBRA coverage until the earlier of: recovery of the pre-existing condition; or the end of the COBRA eligibility period for any reason.
- The date the individual continuing coverage becomes entitled to benefits under Medicare.

COBRA payments are due within 45 days from the date of application. Payments must be made retroactively from the date of COBRA eligibility up through the current month of eligibility.

Contact your Department Human Resources or Payroll Representative for more information.

How the Program Works

This program is designed to encourage regular dental care. Each calendar year (January 1 through December 31) WDS pays an increasing share of dental costs. The calendar year is also referred to as your benefit period.

Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.

Benefits Covered By Your Program

The following are Class I, Class II and Class III Covered Dental Benefits under this program which are subject to the limitations and exclusions described in this booklet.

Class I

Diagnostic

Covered Dental Benefits

- Routine examination (periodic oral evaluation)
- Comprehensive oral evaluation
- X-rays
- Emergency examination
- Specialist examination performed by a specialist in an American Dental Association-recognized specialty
- WDS-approved caries (tooth decay) and periodontal susceptibility/risk tests

Limitations

- Routine examination is covered twice in a benefit period.
- Comprehensive oral evaluation is covered once in a three-year period from the date of service per eligible person per dentist. Additional comprehensive oral evaluations are allowed as routine examinations.
  - Comprehensive oral evaluations are considered as one of the two covered examinations per benefit period.
- Complete series (any number or combination of intraoral X-rays, billed for same date of service, that equals or exceeds the allowed fee for a complete series is considered a complete series for payment purposes) or panorex X-rays are covered once in a three-year period from the date of service.
- Supplementary bitewing X-rays are covered twice in a benefit period.
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I benefits.

Exclusions

- Consultations or elective second opinions
- Study models

Preventive

Covered Dental Benefits

- Prophylaxis (cleaning)
- Periodontal maintenance
- Fissure sealants
- Topical application of fluoride or preventive therapies, e.g. fluoridated varnishes
- Space maintainers (with limitations)

Limitations

- —General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III and Orthodontic covered dental procedures.
- —Either general anesthesia or intravenous sedation (but not both) are covered when performed on the same day.
- —General anesthesia for routine post-operative procedures is not a paid covered benefit.

Intravenous Sedation

Covered Dental Benefits

- —Intravenous sedation when administered by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- —Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS.
- —Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- —Intravenous sedation for routine post-operative procedures is not a paid covered benefit.

Palliative Treatment

Covered Dental Benefits

- —Palliative treatment for pain

Limitations

- —Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

Restorative

Covered Dental Benefits

- —Amalgam restorations (fillings) and, in anterior (front) teeth, resin-based composite or glass ionomer restorations are covered for the following reasons:
  - o Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - o Fracture resulting in significant loss of tooth structure (missing cusp)
  - o Fracture resulting in significant damage to an existing restoration
- —Resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspids.
- —Stainless steel crowns

— A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth, whether or not a removable partial denture is part of the treatment.
— Crowns or onlays are not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.
— Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a paid covered benefit.
— Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a paid covered benefit.

Exclusions

— Overhang removal
— Copings
— Re-contouring or polishing of restoration

Oral Surgery

Covered Dental Benefits

— Removal of teeth
— Preparation of the mouth for insertion of dentures
— Treatment of pathological conditions and traumatic injuries of the mouth
— *Refer to Class II General Anesthesia or Intravenous Sedation for information.*

Exclusions

— Bone replacement graft for ridge preservation
— Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth
— Tooth transplants
— Materials placed in tooth extraction sockets for the purpose of generating osseous filling

Periodontics

Covered Dental Benefits

— Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
— Services covered include:
  - Periodontal scaling/root planing
  - Periodontal surgery
  - Limited adjustments to occlusion (eight teeth or fewer)
  - WDS-approved localized delivery of antimicrobial agents
— *Refer to Class I Preventive for periodontal maintenance benefits.*
— *Refer to Class III Periodontics for occlusal equilibration and occlusal guard.*

Note: *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered dental benefit. A predetermination is not a guarantee of payment.*

Class III

Note: *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.*

Periodontics

Covered Dental Benefits

- Under certain conditions of oral health, services covered are:
  - Occlusal guard (nightguard)
  - Repair and relines of occlusal guard
  - Complete occlusal equilibration

Note: *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered dental benefit. A predetermination is not a guarantee of payment.*

Limitations

- Occlusal guard (nightguard) is covered once in a three-year period from the date of service.
- Repair and relines done more than six months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

Prosthodontics

Covered Dental Benefits

- Dentures
- Fixed partial dentures (fixed bridges)
- Inlays (only when used as a retainer for a fixed bridge)
- Removable partial dentures
- Adjustment or repair of an existing prosthetic device
- Surgical placement or removal of implants or attachments to implants

Limitations

- Replacement of an existing prosthetic device is covered only once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Inlays are a covered dental benefit on the same teeth once in a five-year period from the delivery date only when used as a retainer for a fixed bridge.
- Payment for dentures, fixed partial dentures (fixed bridges); inlays (only when used as a retainer for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Replacement of implants and superstructures is covered only after five years have elapsed from any prior provision of the implant.
- Implant maintenance procedures, including:
  - Removal of prosthesis
  - Cleansing of prosthesis and abutments
  - Reinsertion of prosthesis
- Crowns in conjunction with overdentures are not a paid covered benefit.

Limitations

- —Payment is limited to:
  - o Completion, or through limiting age (refer to Dependent Eligibility and Termination), whichever occur first.
  - o Treatment received after coverage begins (claims must be submitted to WDS within the time limitation stated in the Claim Forms Section of the start of coverage). For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.
- —Treatment that began prior to the start of coverage will be prorated:
  - o Payment is made based on the balance remaining after the down payment and charges prior to the date of eligibility are deducted.
  - o WDS will issue payments based on our responsibility for the length of the treatment. The payments are issued providing the employee is eligible and the dependent is in compliance with the age limitation.
- —In the event of termination of the treatment plan prior to completion of the case or termination of this plan, no subsequent payments will be made for treatment incurred after such termination date.

Exclusions

- —Charges for replacement or repair of an appliance
- —No benefits shall be provided for services considered inappropriate and unnecessary, as determined by WDS.

****Refer also to General Limitations and General Exclusions****

Additional Procedures

In some cases, there may be two or more treatment options that meet the standard of care for dental needs covered by the plan. In such instances, the plan will pay the proper percentage of the lowest fee. The balance of treatment cost remains the eligible person's responsibility.

General Limitations

1. Dentistry for cosmetic reasons is not a paid covered benefit.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are not a paid covered benefit.
3. General anesthesia/intravenous (deep) sedation is not a paid covered benefit, except as specified by WDS for certain oral, periodontal, or endodontic surgical procedures. General anesthesia is not a paid covered benefit except when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.

11. Habit-breaking appliances
12. TMJ services or supplies
13. This plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
14. All other services not specifically included in this plan as covered dental benefits.

WDS shall determine whether services are Covered Dental Benefits in accordance with standard dental practice and the Limitations and Exclusions shown in this benefits booklet. Should there be a disagreement regarding the interpretation of such benefits, the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this benefits booklet and may seek judicial review of any denial of coverage of benefits.

Claim Review and Appeal

Predetermination of Benefits

A predetermination is a request made by your dentist to Washington Dental Service to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services. Please be aware that the predetermination is not a guarantee of payment but strictly an estimate for services. Payment for services is determined when the claim is submitted (please refer to the Initial Benefits Determination section regarding claims requirements).

A standard predetermination is processed within 15 days from the date of receipt if all appropriate information is completed. If it is incomplete, Washington Dental Service may request additional information, request an extension of 15 days and pend the predetermination until all of the information is received. Once all of the information is received a determination will be made within 15 days of receipt. If no information is received at the end of 45 days, the predetermination will be denied.

Urgent Predetermination Requests

Should a predetermination request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, Washington Dental Service will review the request within 72-hours from receipt of the request and all supporting documentation. When practical, WDS may provide notice of determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

Washington Dental Service will review your claim and make a determination within 30 days of receiving your request and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision.

Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, Washington Dental Service will consult with a dental professional advisor.

Appeals Committee

If you are dissatisfied with the outcome of the informal review, you may request that your claim be reviewed formally by the Washington Dental Service Appeals Committee. This Committee includes only persons who were not involved in either the original claim decision or the informal review.

Your request for a review by the Appeals Committee must be made within 90 days of the post-marked date of the letter notifying you of the informal review decision. Your request should include the information noted above plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim and make a determination within 30 days of receiving your request or within 20 days for experimental/investigational procedures appeals and sends you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

The decision of the Appeals Committee is final. If you disagree with this the outcome of your appeal and you have exhausted the appeals process provided by your group plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter.

Authorized Representative

You may authorize another person to represent you and to whom Washington Dental Service can communicate regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form not be returned or any document confirming the right of the individual to act on your behalf (i.e., power of attorney), the appeal will be closed.

- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To Receive The Best Oral Health Care Possible, It Is Your Responsibility To:

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents that you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to Washington Dental Service to assist with the processing of claims.
- If applicable, pay the dental office the appropriate co-payments amount at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.

Inform your dentist and your employer promptly of any change to your or a family member's address, telephone, or family status.

Washington Dental Service, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our community since 1954. Today we cover more than 50 million people nationwide through our Delta Dental plans.

We specialize exclusively in dental benefits, which allows us to offer the most knowledgeable customer service and to partner with our large participating dentist networks to offer you the widest choice of dentists. We are an innovative company that is a national leader in supporting dental research so that we can include the latest effective dental treatments in our plans. Healthy teeth for a wonderful smile – that is what we are all about!

To learn more about Washington Dental Service and your benefits, visit our Internet Web site at **www.DeltaDentalWA.com**.

Plan Administered by:

Personnel Department

City of Seattle

City of Seattle Policy #3
Seattle Police Officer's Guild

Group #00160

Effective January 1, 2011, the following benefit information has been revised or added in your Benefit Booklet. We have identified the section that is changing with all **changes in bold print**.

Dependent Eligibility

Eligible Dependents include:

- The employee's legal spouse/state registered domestic partner or non-registered domestic partner named on the Affidavit of Marriage/Domestic Partnership on file with the City.
- Natural, adopted, legally placed ward or stepchild from birth through **25**. Spouses and children of married dependents are not eligible for coverage under this plan.
- In the case of divorced parents, children are eligible and may be enrolled by the parent (an eligible employee) who is legally responsible for health care benefits, regardless of whether or not the child is primarily dependent upon the employee for support. The child shall be eligible from birth through **25**.

Coverage for **a dependent child** over the limiting age will not be terminated if the child is and continues to be both 1) incapable of self sustaining employment by reasons of developmental disability (including mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals) or physical handicap and 2) chiefly dependent upon the eligible person for support and maintenance, provided proof of incapacity and dependency is furnished to WDS within 31 days of the child's attainment of the limiting age and the child was an eligible dependent upon attainment of the limiting age. WDS reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

When *This Plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan*'s benefits. When *This Plan* is secondary, it determines its benefits after those of another *Plan* and must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plans* for the claim are coordinated up to 100 percent of the total *Allowable Expense* for that claim. This means that when *This Plan* is secondary, it must pay the amount which, when combined with what the *Primary Plan* paid, does not exceed 100 percent of the highest *Allowable Expense*. In addition, if *This Plan* is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the *Primary Plan*) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an *Allowable Expense* under *This Plan*. If *This Plan* is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

"*Allowable Expense*" is a dental care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the *Plans* covering you. When coordinating benefits, any *Secondary Plans* must pay an amount which, together with the payment made by the *Primary Plan*, does not exceed the higher of the allowable expenses. In no event will a *Secondary Plan* be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or a portion of an expense that is not covered by any of the *plans* is not an allowable expense. The following are examples of expenses that are not *Allowable Expenses*:

- If you are covered by two or more *Plans* that compute their benefit payments on the basis of a relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by two or more *Plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *Allowable Expense*.

"*Closed Panel Plan*" is a *Plan* that provides dental benefits to you in the form of services through a panel of providers who are primarily employed by the *Plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

"*Custodial Parent*" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules: When you are covered by two or more *Plans*, the rules for determining the order of benefit payments are as follows:

The *Primary Plan* must pay or provide its benefits as if the *Secondary Plan* or *Plans* did not exist.

e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:

I. The *Plan* covering the *Custodial Parent*, first;
II. The *Plan* covering the spouse of the *Custodial Parent*, second;
III. The *Plan* covering the non*custodial Parent*, third; and then
IV. The *Plan* covering the spouse of the non*custodial Parent*, last

3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

"*Active Employee or Retired or Laid-off Employee:*" The *Plan* that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary Plan*. The *Plan* covering you as a retired or laid-off employee is the *Secondary Plan*. The same would hold true if you are a *Dependent* of an active employee and you are a *Dependent* of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"*COBRA or State Continuation Coverage:*" If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering you as an employee, member, subscriber or retiree or covering you as a *Dependent* of an employee, member, subscriber or retiree is the *Primary Plan* and the COBRA or state or other federal continuation coverage is the *Secondary Plan*. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"*Longer or Shorter Length of Coverage:*" The *Plan* that covered you as an employee, member, policyholder, subscriber or retiree longer is the *Primary Plan* and the *Plan* that covered you the shorter period of time is the *Secondary Plan*.

If the preceding rules do not determine the order of benefits, the *Allowable Expense*s must be shared equally between the *Plan*s meeting the definition of *Plan*. In addition, *This Plan* will not pay more than it would have paid had it been the *Primary Plan*.

Effect on the Benefits of *This Plan*: When *This Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plan*s during a claim determination period are not more than the *Total Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary Plan* must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim do not exceed 100 percent of the total *Allowable Expense* for that claim. Total *Allowable Expense* is the highest *Allowable Expense* of the *Primary Plan* or the *Secondary Plan*. In addition, the *Secondary Plan* must credit to its *Plan* deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

If payments that should have been made under *This Plan* are made by another *Plan*, WDS has the right, at its discretion, to remit to the other *Plan* the amount it determines appropriate. To the extent of such payments, WDS is fully discharged from liability under *This Plan*.

Notice to covered persons If you are covered by more than one health benefit *Plan*, and you do not know which is your *Primary Plan*, you or your provider should contact any one of the health *Plan*s to verify which *Plan* is primary. The health *Plan* you contact is responsible for working with the other health *Plan* to determine which is primary and will let you know within 30 calendar days.

CAUTION: All health *Plan*s have timely claim filing requirements. If you, or your provider, fail to submit your claim to a secondary health *Plan* within the *Plan*'s claim filing time limit, the *Plan* can deny the claim. If you experience delays in the processing of your claim by the primary health *Plan*, you or your provider will need to submit your claim to the secondary health *Plan* within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one *Plan* you should promptly report to your providers and *Plan*s any changes in your coverage.

American Recovery and Reinvestment Act (ARRA)

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium reductions and additional election opportunities for health benefits under COBRA. The premium reduction applies to periods of health coverage beginning on or after February 17, 2009 **and lasts for the time period established by law** for those eligible for COBRA due to an involuntary termination period, as defined by the ARRA.